carditic effusion usually occasions. The movements of the heart, floating freely in the fluid, are not much obstructed; though, when the pericardium is fully distended, the heart must be subjected to compression, resisting the free expansion of its cavities, especially those of the right side, for the reception of fresh supplies of blood, and thus tending to produce venous congestion.

I think we may, however, conclude that the actual amount of effusion was not so large as the vertical extent of dulness might lead us to suppose. The area of dulness had never a corresponding lateral extension; the median line on the sternum was the limit of its extension to the right. It is in chronic cases, in which the pericardium yields to protracted tension, that it becomes expanded laterally into a globular form; but in recent cases the sac retains its more conical figure, rising high towards the clavicle, but without much breadth. This is the only explanation I can suggest of the patient's remarkable freedom from distress even when the pericardial dulness mounted upwards to the clavicle.

The treatment requires no special remark; it was in accordance with recognised principles, as I have explained on former occasions. Some practitioners would have regarded the presence of a considerable amount of fluid in the pericardium as in itself an indication for *tapping*, irrespectively of any amount of distress or immediate danger which it occasioned. In the case to which I have already alluded, I have given my own reasons for not taking this view; and in both cases my own more cautious expectancy has proved that a more daring treatment was unnecessary. The absorption of the fluid was as prompt and decisive as had been its effusion. The whole process was completed within three weeks. Whilst the absorption of the fluid was in progress, the urine was tested for albumen, the absorption of serous fluid being occasionally one of the causes of a temporary albuminuria; but no albumen was present.

So far as concerns the pericarditis, we may consider the recovery to be complete. The form of the inflammation would not be accompanied with much fibrinous deposit; and, by the prompt subsidence of the morbid action and rapid absorption of its products, all subsequent unfavourable results would be obviated. Some valvular defect remains, which must prevent his restoration to perfect soundness. The mental weakness which he exhibited during early convalescence was the result of physical weakness, and has disappeared with recovered strength.

ON THE TREATMENT OF ASTHMA.

By GEORGE GASKOIN, Esq.,
Surgeon to the British Hospital for Diseases of the Skin.

IN the summer of 1870, I was summoned to a lady suffering from an acute attack of asthma. For several nights she had been restricted to the sitting posture, bent over a table, with the forehead resting on her hands. The distress was very great indeed. She was subject to frequent attacks of the kind, complicated to a very moderate extent with catarrh and bronchitic exudation. Her physician, a gentleman who holds high professional rank, was out of town. Nothing had been omitted in the treatment, which of late was simply palliative. She was recognised as constitutionally asthmatic, and little hope was entertained of permanent amendment. The asthma first occurred on the subsidence of nervous symptoms a few years previous. It had not, as far as I am aware, any marked organic basis. There was observable on the legs an eczematous eruption. Under these circumstances, I directed that the chloroform liniment of the *British Pharmacopœia* should be rubbed briskly into the chest for an hour's space, if possible; and this was done daily by a very efficient attendant, who had sufficient intelligence to comprehend and carry out the treatment. Very early, much relief was experienced. On the return of her physician to town at the end of three days, she was already so very much changed for the better, that he directed the treatment to be continued. From that time it consisted in the daily repetition of the rubbing process for a month or nearly so, without aid from medicine, and with little restriction as to diet. Beyond the information I received that she was daily improving, I had really little or nothing to do with her professionally after one or two visits. Under the hands of her attendant, she speedily got rid of the asthma. The patient went out of town in the autumn, and enjoyed perfect health and spirits. She took much walking exercise, with exposure, in the cold of the ensuing winter; and, what is very singular, two years have since elapsed with no return of the asthma.

I shall now make a few observations on this method of treatment. For some years, in Paris, asthmatics have been in the habit of resorting o a rubber in the Boulevard Saint Michel, a certain Widow Pau, who pursues there very much the method which I have laid down, only that her nostrum is a secret. She is resorted to by a few wealthy people from this country, and has honourable mention in some of our West End clubs. At the end of the treatment, her patients are presented with a little book or *brochure* containing her successes, which may be said to be fairly written for a book of its class. The cure is subject to disappoint for a few days; but generally great benefit will be found in a fortnight, or even in less time. There is a hint that it is best suited to cases with catarrhal and bronchitic complication. The instance which I have here brought forward seems exactly to correspond with those which are boasted of and detailed historically by Madame Pau.

Before giving directions as to how this treatment should be carried out, I will speak as to the *rationale*. Counterirritation, especially by blister, issue, and moxa, are of such well established repute in the treatment of asthma, that I need not dwell on them; but, besides this, a jolting vehicle, anything that leads to displacement of the air stagnant in the vesicles, is proved to give relief in many instances. I should advise, then, that the frictions should be made with such roughness as the case admits. Slight blows with the palm of the hand or the end of a towel on the ribs are quite allowable; and the friction should be extended to the front of the neck at the lower part, where the vagi enter the chest. I do not think that the composition of the liniment need trouble us, provided it be warm and work easily. Anything like Roche's embrocation would answer very well.

I am not without some experience of asthma, and I am persuaded that the present method will be found a valuable addition to our therapeutic means. If proved not to be novel, it must be conceded that it has fallen into utter neglect.

PARACENTESIS IN PLEURISY AND EMPYEMA.

By HENRY WILLIAM FULLER, M.D., F.R.C.P.,
Physician to St. George's Hospital.

THE questions which arise in connection with tapping are so important, and there is so much need for a clear recognition of the *facts* which bear upon the subject, that I must ask permission to make a few remarks as a supplement to the abstract of my clinical lecture reported in the JOURNAL of February 3rd.

It is conceded on all hands that, when the fluid effused into the pleural cavity is simple serum, it is advisable to take precautions against the admission of air. No valid reason exists why air should be admitted; and, as the patient can be readily relieved without its admission, it would be obviously unwise to incur even the slightest risk by making a free opening into the pleura. Observation, however, has led me to attach very slight importance to the entrance of air into the pleural cavity; and I am satisfied that the feeling which exists in the minds of many as to its danger originates in prejudice fostered by tradition, rather than in the results of bedside experience.

At the commencement of my professional career, the doctrine was taught that the admission of air into a serous cavity was almost necessarily fatal. So strong a hold had this theoretical view on the current practice of the day, that the pleura was rarely punctured—never, indeed, until the patient was almost beyond the possibility of recovery. By degrees the mischievous absurdity of this doctrine became apparent; and the continued successes of Mr. Spencer Wells and others in cases of ovariotomy have gone far to dispel the illusion, that air admitted into a serous cavity usually sets up putrefactive changes in the secretion of that cavity. Still, many persons remain who cannot emancipate themselves from the thraldom of tradition, and whose minds remain a prey to that morbid fear of consequences which induced our predecessors to withhold from their patients the relief afforded by puncture of a distended pleura. In the JOURNAL of February 17th, Dr. Douglas Powell proclaims himself one of those who are terrified at results which I venture to think they have never witnessed, and which exist only in their own imagination. He objects to the admission of air because "it tends to produce such changes in the fluid as cause it to become noxious, and to set up fresh pleurisy." I can only say that, during the whole period of my connection with St. George's Hospital—now upwards of twenty years—I have never seen the fearful mischief thus theoretically predicted by Dr. Powell. In cases of simple serous effusion, I have thought it wiser to defer to the prejudice thus enunciated by Dr. Powell, and have founded my teaching upon it, for the simple reason that in cases of serous effusion no harm could result from my so doing. But in practice I have taken no special precaution to prevent the admission of air. Every case has been tapped which has not yielded to ordinary treatment, and the operation has been performed